Early Periodic Screening and Diagnostic Testing (EPSDT)
September 2007 Seminar Registration Form
(No Fee)

Provider Name_____

Medicaid Provider Number_____NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____E-mail_____

Telephone Number(____)_____Fax Number_____

_____# of persons attending the seminar at _____on_____
(location) (date)

Please fax completed form to 919-851-4014 or
Please mail completed form to
EDS Provider Services
P.O. Box 300009
Raleigh NC 27622